

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12568

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 35 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 505 High St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
3. NAME OF DECEASED (Type or print) First Middle Last Lillian Lloyd Allen		4. DATE OF DEATH Month Day Year Dec. 9, 19 56	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown
9. AGE (In years last birthday) 80 yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John H. Allen		14. MOTHER'S MAIDEN NAME Sallie (Sarah) Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT J. Thos. Powell		Address Hotel 2400 Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid and subdural hemorrhage don't know 904.0 DUE TO The & focal petechial cortical hemorrhage recent Conditions, if any, which gave rise to immediate cause (b) Head injury probably sustained in a fall (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive CVD with coronary sclerosis & old infarct 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown	
20c. TIME OF INJURY Month, Day, Year Hour a. m. don't know p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Chestertown (County) Kent (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Farr		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 14 1956	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) Baltimore City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR Dec. 13-56		24b. REGISTRAR'S SIGNATURE Clara L. Barnes	

...MEDICAL EXAMINER'S CERTIFICATE OF DEATH.

BUREAU V.

1956 41 350

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12569

12597

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY KENT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY KENT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN		c. LENGTH OF STAY IN 1b 1 YEAR		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN		37	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT & QUEEN ANNE'S				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DELLA Middle L. Last BARNES				4. DATE OF DEATH Month DEC Day 26 Year 1956			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR 2, 1877		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME SAMUEL LEE				14. MOTHER'S MAIDEN NAME SCHUSTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT HOSP. CHART.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) POST-OPERATIVE: RESECTION OF DUODENAL TUMOR						INTERVAL BETWEEN ONSET AND DEATH 12 HRS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12:15 , 19 56 , to 12:26 , 19 56 , that I last saw the deceased alive on 12:26 , 19 56 , and that death occurred at 6:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) CHESTERTOWN MD DATE SIGNED 12-26-56							
ACTUAL SIGNATURE A. T. Keefe, Jr.		M.D. CHESTERTOWN MD					
PHYSICIAN'S NAME (Type) A. T. KEEFE, JR. M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Dec. 28, 1956		22c. NAME OF CEMETERY OR CREMATORY Chester Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR Dec. 27-56	
				24b. REGISTRAR'S SIGNATURE Clara S. Barnes			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. DATE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CLERK	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF SHERIFF		18. SIGNATURE OF CORONER	
19. SIGNATURE OF DEPUTY CLERK		20. SIGNATURE OF DEPUTY SHERIFF		21. SIGNATURE OF DEPUTY CORONER	
22. SIGNATURE OF DEPUTY JUDGE		23. SIGNATURE OF DEPUTY SHERIFF		24. SIGNATURE OF DEPUTY CORONER	
25. SIGNATURE OF DEPUTY JUDGE		26. SIGNATURE OF DEPUTY SHERIFF		27. SIGNATURE OF DEPUTY CORONER	
28. SIGNATURE OF DEPUTY JUDGE		29. SIGNATURE OF DEPUTY SHERIFF		30. SIGNATURE OF DEPUTY CORONER	
31. SIGNATURE OF DEPUTY JUDGE		32. SIGNATURE OF DEPUTY SHERIFF		33. SIGNATURE OF DEPUTY CORONER	
34. SIGNATURE OF DEPUTY JUDGE		35. SIGNATURE OF DEPUTY SHERIFF		36. SIGNATURE OF DEPUTY CORONER	
37. SIGNATURE OF DEPUTY JUDGE		38. SIGNATURE OF DEPUTY SHERIFF		39. SIGNATURE OF DEPUTY CORONER	
40. SIGNATURE OF DEPUTY JUDGE		41. SIGNATURE OF DEPUTY SHERIFF		42. SIGNATURE OF DEPUTY CORONER	
43. SIGNATURE OF DEPUTY JUDGE		44. SIGNATURE OF DEPUTY SHERIFF		45. SIGNATURE OF DEPUTY CORONER	
46. SIGNATURE OF DEPUTY JUDGE		47. SIGNATURE OF DEPUTY SHERIFF		48. SIGNATURE OF DEPUTY CORONER	
49. SIGNATURE OF DEPUTY JUDGE		50. SIGNATURE OF DEPUTY SHERIFF		51. SIGNATURE OF DEPUTY CORONER	
52. SIGNATURE OF DEPUTY JUDGE		53. SIGNATURE OF DEPUTY SHERIFF		54. SIGNATURE OF DEPUTY CORONER	
55. SIGNATURE OF DEPUTY JUDGE		56. SIGNATURE OF DEPUTY SHERIFF		57. SIGNATURE OF DEPUTY CORONER	
58. SIGNATURE OF DEPUTY JUDGE		59. SIGNATURE OF DEPUTY SHERIFF		60. SIGNATURE OF DEPUTY CORONER	
61. SIGNATURE OF DEPUTY JUDGE		62. SIGNATURE OF DEPUTY SHERIFF		63. SIGNATURE OF DEPUTY CORONER	
64. SIGNATURE OF DEPUTY JUDGE		65. SIGNATURE OF DEPUTY SHERIFF		66. SIGNATURE OF DEPUTY CORONER	
67. SIGNATURE OF DEPUTY JUDGE		68. SIGNATURE OF DEPUTY SHERIFF		69. SIGNATURE OF DEPUTY CORONER	
70. SIGNATURE OF DEPUTY JUDGE		71. SIGNATURE OF DEPUTY SHERIFF		72. SIGNATURE OF DEPUTY CORONER	
73. SIGNATURE OF DEPUTY JUDGE		74. SIGNATURE OF DEPUTY SHERIFF		75. SIGNATURE OF DEPUTY CORONER	
76. SIGNATURE OF DEPUTY JUDGE		77. SIGNATURE OF DEPUTY SHERIFF		78. SIGNATURE OF DEPUTY CORONER	
79. SIGNATURE OF DEPUTY JUDGE		80. SIGNATURE OF DEPUTY SHERIFF		81. SIGNATURE OF DEPUTY CORONER	
82. SIGNATURE OF DEPUTY JUDGE		83. SIGNATURE OF DEPUTY SHERIFF		84. SIGNATURE OF DEPUTY CORONER	
85. SIGNATURE OF DEPUTY JUDGE		86. SIGNATURE OF DEPUTY SHERIFF		87. SIGNATURE OF DEPUTY CORONER	
88. SIGNATURE OF DEPUTY JUDGE		89. SIGNATURE OF DEPUTY SHERIFF		90. SIGNATURE OF DEPUTY CORONER	
91. SIGNATURE OF DEPUTY JUDGE		92. SIGNATURE OF DEPUTY SHERIFF		93. SIGNATURE OF DEPUTY CORONER	
94. SIGNATURE OF DEPUTY JUDGE		95. SIGNATURE OF DEPUTY SHERIFF		96. SIGNATURE OF DEPUTY CORONER	
97. SIGNATURE OF DEPUTY JUDGE		98. SIGNATURE OF DEPUTY SHERIFF		99. SIGNATURE OF DEPUTY CORONER	
100. SIGNATURE OF DEPUTY JUDGE		101. SIGNATURE OF DEPUTY SHERIFF		102. SIGNATURE OF DEPUTY CORONER	

RECEIVED
DEC 1 1956
BUREAU Y. R.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12570

12596

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH o. COUNTY <u>KENT</u> <u>Chestertown</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN RURAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RURAL CHESTERTOWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				1. d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clydea</u> First <u>Barton</u> Middle Last				4. DATE OF DEATH <u>Dec</u> Month <u>17</u> Day <u>1956</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 11 1881</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS Coleman</u>				14. MOTHER'S MAIDEN NAME <u>LOUISA Wells</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>—</u>		17. INFORMANT <u>Thelma L. Price</u> Address <u>Fairlee Chestertown</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Heart Failure</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes mellitus - cystitis - 1</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. <u>11</u> p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Dec. 12, 1956</u> , to <u>Dec. 12, 1956</u> , that I last saw the deceased alive on <u>Dec. 12, 1956</u> , and that death occurred at <u>8 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas J. Solon</u>				ADDRESS (Street, city or town, state) <u>M.D. Chestertown, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>THOMAS J. SOLON</u>				DATE SIGNED <u>12/18/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 20</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		22d. LOCATION (City, town, or county) <u>Park Hall Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar A. Rane</u>				ADDRESS <u>Church Hill Ind.</u>		24a. REC'D BY REGISTRAR <u>Dec. 22-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>							

1956

BUREAU V. S.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												12571
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												Reg. Dist. No. 201
12538												
1. PLACE OF DEATH a. COUNTY <i>rent</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) o. STATE <i>md.</i> b. COUNTY <i>rent</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesutown</i>						c. LENGTH OF STAY IN 1b						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Galtz</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>rent H. Queen Anna Hospital</i>						d. STREET ADDRESS <i>1</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>LOUIS</i> Middle <i>BROOKS</i> Last						4. DATE OF DEATH Month <i>DECEMBER</i> Day <i>26</i> Year <i>1956</i>						
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Calver</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 2, 1902</i>		9. AGE (In years last birthday) <i>54</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm labor</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>				11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Robert Brooks</i>						14. MOTHER'S MAIDEN NAME <i>Charon Benson</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <i>220-16-9259</i>		17. INFORMANT <i>Robert Brooks</i> Address <i>Galtz md.</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.2</i> Drug Intoxication <i>POSSIBLE Intoxication</i> DUE TO <i>bad mistake</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Contusions of abrasions buttocks + back</i> (c) <i>miniature hemorrhage - cerebellum</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>1. Lower nephron nephrosis and 2. Myocarditis with softening of muscle</i> INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>(?) 5 days</i> <i>(?) 5 days</i>												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .												
ACTUAL SIGNATURE <i>Robert W. Farr</i>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <i>12/26/56</i>
EXAMINER'S NAME (Type) <i>ROBERT W. FARR</i>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, OR OTHER (Specify) <i>Burial</i>				22b. DATE THEREOF <i>Dec 30/1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Wesley Henry Cem.</i>				22d. LOCATION (City, town, or county) (State) <i>Galtz md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edmond J. Villanar</i>						ADDRESS <i>Millington md.</i>		24a. REC'D BY REGISTRAR <i>JAN 3 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Clara Benson</i>		

37

72

1

2

2

BP

BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12572

12589

CERTIFICATE OF DEATH

Reg. Dist. No.

200

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Mulling's cor</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Anne General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>DELLA</u> Last <u>BURRIS</u>			4. DATE OF DEATH Month <u>December</u> Day <u>10</u> Year <u>1956</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 24, 1924</u>		9. AGE (In years lost birthday) <u>32</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. a</u>	
13. FATHER'S NAME <u>Gilbert Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Alberta Hackett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-20-1881</u>		17. INFORMANT Address <u>Deceased - from hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized convulsive seizure (Edamysia?)</u> DUE TO <u>Arterial hypertension in</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Don't know</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pregnancy - full term - (Outpartum death)</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11/13</u> , 1956, to <u>12-10</u> , 1956, that I last saw the deceased alive on <u>12-10</u> , 1956, and that death occurred at <u>5:40 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert W. Farr</u>				ADDRESS (Street, city or town, state) <u>Chestertown, Md</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT W. FARR</u>				DATE SIGNED <u>12-10-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 13, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chubsville Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Chubsville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Bellows Mullington Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 17 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Charles H. Barnes</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12573

12590

CERTIFICATE OF DEATH

Reg. Dist. No.

202

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 7</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Died in ambulance</u>		d. STREET ADDRESS <u>3605 Patterson</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Henry Lloyd Carter</u>		4. DATE OF DEATH Month Day Year <u>December 7 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 4, 1886</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u>	
11. BIRTHPLACE (State or foreign country) <u>Chestertown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Carter</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Rollison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>213-10-143</u>	
17. INFORMANT <u>Mrs. H.L. Carter</u>		Address <u>3607 Patterson-Balto.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>3 months?</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-7-</u> , 19 <u>56</u> , to <u>12-7-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-7-</u> , 19 <u>56</u> , and that death occurred at <u>12:50 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u> DATE SIGNED <u>12-7-56</u>			
ACTUAL SIGNATURE <u>A.C. Dick</u>		M.D. _____	
PHYSICIAN'S NAME (Type) <u>A.C. Dick, M.D.</u>		_____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 10, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>		ADDRESS <u>Chestertown, Md.</u>	
24a. REC'D BY REGISTRAR <u>Dec. 8-56</u>		24b. REGISTRAR'S SIGNATURE <u>Class S. Barnes</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MEDICAL HISTORY</p>		<p>10. SIGNATURE OF PHYSICIAN</p>	
<p>11. SIGNATURE OF REGISTRAR</p>		<p>12. DATE OF DEATH</p>	
<p>13. PLACE OF DEATH</p>		<p>14. TIME OF DEATH</p>	
<p>15. SIGNATURE OF WITNESS</p>		<p>16. SIGNATURE OF DECEASED</p>	
<p>17. SIGNATURE OF NEXT OF KIN</p>		<p>18. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>19. SIGNATURE OF FUNERAL HOME</p>		<p>20. SIGNATURE OF CHURCH OFFICIAL</p>	
<p>21. SIGNATURE OF CEMETERY OFFICIAL</p>		<p>22. SIGNATURE OF INTERVIEWER</p>	
<p>23. SIGNATURE OF INTERVIEWER</p>		<p>24. SIGNATURE OF INTERVIEWER</p>	
<p>25. SIGNATURE OF INTERVIEWER</p>		<p>26. SIGNATURE OF INTERVIEWER</p>	
<p>27. SIGNATURE OF INTERVIEWER</p>		<p>28. SIGNATURE OF INTERVIEWER</p>	
<p>29. SIGNATURE OF INTERVIEWER</p>		<p>30. SIGNATURE OF INTERVIEWER</p>	
<p>31. SIGNATURE OF INTERVIEWER</p>		<p>32. SIGNATURE OF INTERVIEWER</p>	
<p>33. SIGNATURE OF INTERVIEWER</p>		<p>34. SIGNATURE OF INTERVIEWER</p>	
<p>35. SIGNATURE OF INTERVIEWER</p>		<p>36. SIGNATURE OF INTERVIEWER</p>	
<p>37. SIGNATURE OF INTERVIEWER</p>		<p>38. SIGNATURE OF INTERVIEWER</p>	
<p>39. SIGNATURE OF INTERVIEWER</p>		<p>40. SIGNATURE OF INTERVIEWER</p>	
<p>41. SIGNATURE OF INTERVIEWER</p>		<p>42. SIGNATURE OF INTERVIEWER</p>	
<p>43. SIGNATURE OF INTERVIEWER</p>		<p>44. SIGNATURE OF INTERVIEWER</p>	
<p>45. SIGNATURE OF INTERVIEWER</p>		<p>46. SIGNATURE OF INTERVIEWER</p>	
<p>47. SIGNATURE OF INTERVIEWER</p>		<p>48. SIGNATURE OF INTERVIEWER</p>	
<p>49. SIGNATURE OF INTERVIEWER</p>		<p>50. SIGNATURE OF INTERVIEWER</p>	
<p>51. SIGNATURE OF INTERVIEWER</p>		<p>52. SIGNATURE OF INTERVIEWER</p>	
<p>53. SIGNATURE OF INTERVIEWER</p>		<p>54. SIGNATURE OF INTERVIEWER</p>	
<p>55. SIGNATURE OF INTERVIEWER</p>		<p>56. SIGNATURE OF INTERVIEWER</p>	
<p>57. SIGNATURE OF INTERVIEWER</p>		<p>58. SIGNATURE OF INTERVIEWER</p>	
<p>59. SIGNATURE OF INTERVIEWER</p>		<p>60. SIGNATURE OF INTERVIEWER</p>	
<p>61. SIGNATURE OF INTERVIEWER</p>		<p>62. SIGNATURE OF INTERVIEWER</p>	
<p>63. SIGNATURE OF INTERVIEWER</p>		<p>64. SIGNATURE OF INTERVIEWER</p>	
<p>65. SIGNATURE OF INTERVIEWER</p>		<p>66. SIGNATURE OF INTERVIEWER</p>	
<p>67. SIGNATURE OF INTERVIEWER</p>		<p>68. SIGNATURE OF INTERVIEWER</p>	
<p>69. SIGNATURE OF INTERVIEWER</p>		<p>70. SIGNATURE OF INTERVIEWER</p>	
<p>71. SIGNATURE OF INTERVIEWER</p>		<p>72. SIGNATURE OF INTERVIEWER</p>	
<p>73. SIGNATURE OF INTERVIEWER</p>		<p>74. SIGNATURE OF INTERVIEWER</p>	
<p>75. SIGNATURE OF INTERVIEWER</p>		<p>76. SIGNATURE OF INTERVIEWER</p>	
<p>77. SIGNATURE OF INTERVIEWER</p>		<p>78. SIGNATURE OF INTERVIEWER</p>	
<p>79. SIGNATURE OF INTERVIEWER</p>		<p>80. SIGNATURE OF INTERVIEWER</p>	
<p>81. SIGNATURE OF INTERVIEWER</p>		<p>82. SIGNATURE OF INTERVIEWER</p>	
<p>83. SIGNATURE OF INTERVIEWER</p>		<p>84. SIGNATURE OF INTERVIEWER</p>	
<p>85. SIGNATURE OF INTERVIEWER</p>		<p>86. SIGNATURE OF INTERVIEWER</p>	
<p>87. SIGNATURE OF INTERVIEWER</p>		<p>88. SIGNATURE OF INTERVIEWER</p>	
<p>89. SIGNATURE OF INTERVIEWER</p>		<p>90. SIGNATURE OF INTERVIEWER</p>	
<p>91. SIGNATURE OF INTERVIEWER</p>		<p>92. SIGNATURE OF INTERVIEWER</p>	
<p>93. SIGNATURE OF INTERVIEWER</p>		<p>94. SIGNATURE OF INTERVIEWER</p>	
<p>95. SIGNATURE OF INTERVIEWER</p>		<p>96. SIGNATURE OF INTERVIEWER</p>	
<p>97. SIGNATURE OF INTERVIEWER</p>		<p>98. SIGNATURE OF INTERVIEWER</p>	
<p>99. SIGNATURE OF INTERVIEWER</p>		<p>100. SIGNATURE OF INTERVIEWER</p>	

BUREAU V. S.

DEC 11 1956

RECEIVED

12591

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. LENGTH OF STAY IN 1b <u>3 months</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Worton</u> <u>Postoffice</u>				d. STREET ADDRESS <u>R.F.D.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Anne Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>W.</u> Last <u>Comegys</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>9</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 2, 1883</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min.		IF UNDER 24 HRS. Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>			
11. BIRTHPLACE (State or foreign country) <u>Kent Co. Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Alec Comegys</u>				14. MOTHER'S MAIDEN NAME <u>Laura Jane Freeman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-30-2750</u>			
17. INFORMANT <u>Idella Phillips</u>				Address <u>Worton, Md. R.F.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory collapse</u> <u>442X</u> DUE TO <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Thermal burns of hands and arms, in September, 1956, from which he had recovered. General debility.</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>???</u> <u>????</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thermal burns of hands and arms, in September, 1956, from which he had recovered. General debility.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned at home, probably while lighting a fire.</u>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>Sept.</u> 19 <u>56</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Rural-Worton, Kent-Maryland.</u>				(County)		(State)	
21. I certify that I attended the deceased from <u>9-18</u> to <u>12-9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-9</u> , 19 <u>56</u> , and that death occurred at <u>12:15p</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A.C. Dick</u> M.D.				ADDRESS (Street, city or town, state) <u>Chestertown, Maryland</u>			
DATE SIGNED <u>12-10-56</u>							
PHYSICIAN'S NAME (Type) <u>A. C. Dick</u> <u>Chestertown, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 15, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Worton Point Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>nr. - Worton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Willis Wells</u> ADDRESS <u>Chestertown, Md.</u>				24a. REC'D BY REGISTRAR <u>Dec. 11-56</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Barnes</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **202**

12575

12592

1. PLACE OF DEATH o. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown 37
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent and Queen Ann's		d. STREET ADDRESS 303 Kent Circle	
3. NAME OF DECEASED (Type or print) Charles B. Ford First Middle Last		4. DATE OF DEATH Month December Day 18 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 7, 1896
9. AGE (In years last birthday) yrs. 60		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal clerk		10b. KIND OF BUSINESS OR INDUSTRY P.O. Dept.	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Stephen Ford	
14. MOTHER'S MAIDEN NAME Essie Potts		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give year or dates of service) W.W.I	
16. SOCIAL SECURITY NO. none		17. INFORMANT Hospital records, Chestertown, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary oedema 450.0 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Arteriosclerosis Auricular fibrillation (c) 3 days 3 years			INTERVAL BETWEEN ONSET AND DEATH 40 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. s. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-1 , 19 56 to 12-18 , 19 56 , that I last saw the deceased alive on 12-18 , 19 56 , and that death occurred at 10:15a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE A.C. Dick		ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 12-18-56	
PHYSICIAN'S NAME (Type) A.C. Dick			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 21/56	22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery	22d. LOCATION (City, town, or county) (State) Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams, Chestertown, Md.		24a. REC'D BY REGISTRAR Dec 21-56 24b. REGISTRAR'S SIGNATURE Clara J. Barnes	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-1-21-21	
5. PLACE OF BIRTH MOBILE, ALABAMA		6. OCCUPATION None		7. MARITAL STATUS Single		8. COLOR White	
9. DATE OF DEATH 4-4-68		10. TIME OF DEATH 12:00 PM		11. PLACE OF DEATH FBI, MEMPHIS, TENN.		12. CAUSE OF DEATH Suicide by gunshot	
13. MANNER OF DEATH Suicide		14. DISEASE OR INJURY Suicide		15. MEDICAL HISTORY None		16. PREVIOUS ILLNESS None	
17. SIGNATURE OF PHYSICIAN [Signature]		18. SIGNATURE OF CORONER [Signature]		19. SIGNATURE OF WITNESS [Signature]		20. SIGNATURE OF DECEASED None	
21. NAME OF PHYSICIAN [Name]		22. NAME OF CORONER [Name]		23. NAME OF WITNESS [Name]		24. NAME OF DECEASED None	
25. ADDRESS OF PHYSICIAN [Address]		26. ADDRESS OF CORONER [Address]		27. ADDRESS OF WITNESS [Address]		28. ADDRESS OF DECEASED None	
29. CITY OF PHYSICIAN [City]		30. CITY OF CORONER [City]		31. CITY OF WITNESS [City]		32. CITY OF DECEASED None	
33. STATE OF PHYSICIAN [State]		34. STATE OF CORONER [State]		35. STATE OF WITNESS [State]		36. STATE OF DECEASED None	
37. COUNTY OF PHYSICIAN [County]		38. COUNTY OF CORONER [County]		39. COUNTY OF WITNESS [County]		40. COUNTY OF DECEASED None	
41. ZIP CODE OF PHYSICIAN [ZIP]		42. ZIP CODE OF CORONER [ZIP]		43. ZIP CODE OF WITNESS [ZIP]		44. ZIP CODE OF DECEASED None	
45. NAME OF PHYSICIAN [Name]		46. NAME OF CORONER [Name]		47. NAME OF WITNESS [Name]		48. NAME OF DECEASED None	
49. ADDRESS OF PHYSICIAN [Address]		50. ADDRESS OF CORONER [Address]		51. ADDRESS OF WITNESS [Address]		52. ADDRESS OF DECEASED None	
53. CITY OF PHYSICIAN [City]		54. CITY OF CORONER [City]		55. CITY OF WITNESS [City]		56. CITY OF DECEASED None	
57. STATE OF PHYSICIAN [State]		58. STATE OF CORONER [State]		59. STATE OF WITNESS [State]		60. STATE OF DECEASED None	
61. COUNTY OF PHYSICIAN [County]		62. COUNTY OF CORONER [County]		63. COUNTY OF WITNESS [County]		64. COUNTY OF DECEASED None	
65. ZIP CODE OF PHYSICIAN [ZIP]		66. ZIP CODE OF CORONER [ZIP]		67. ZIP CODE OF WITNESS [ZIP]		68. ZIP CODE OF DECEASED None	

BUREAU V. 5

DEC 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12593

CERTIFICATE OF DEATH

12576

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b adult life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) J. Vincent Grinnell		4. DATE OF DEATH Dec. 9, 1956	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 9, 1888
9. AGE (In years last birthday) 68		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY gardener	
11. BIRTHPLACE (State or foreign country) St. Mary's Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sanford Grinnell		14. MOTHER'S MAIDEN NAME Mary (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-36-II47A	
17. INFORMANT Minnie Grinnell		Address RFD Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage DUE TO (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Rock Hall, Md.		20g. (County) (State)	
21. I certify that I attended the deceased from 11-30, 1956, to 12/9, 1956, that I last saw the deceased alive on 12/4, 1956, and that death occurred at 9 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Eugene Kester		DATE SIGNED 12/10/56	
PHYSICIAN'S NAME (Type) Eugene Kester - Rock Hall, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 13, 1956	22c. NAME OF CEMETERY OR CREMATORY Georgetown (col) Cem.	22d. LOCATION (City, town, or county) Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		24a. REC'D BY REGISTRAR Dec. 11-56	
ADDRESS Chestertown, Md.		24b. REGISTRAR'S SIGNATURE Clara J. Barnes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

CERTIFICATE OF DEATH

12577

Reg. Dist. No. 102

12594

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN life <u>life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Anne Hospital</u>		e. STREET ADDRESS <u>600 High St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Clarence E.</u> Middle <u>Hurd</u> Last		4. DATE OF DEATH Month <u>Dec.</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 6, 1910</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months <u>46</u> Days <u>46</u> Hours <u>46</u> Min. <u>46</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mechanic</u>	
11. BIRTHPLACE (State or foreign country) <u>Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles E. Hurd</u>		14. MOTHER'S MAIDEN NAME <u>Florence Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-18-7951</u>	
17. INFORMANT <u>Mrs. Maggie Hurd</u>		Address <u>Chestertown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>141X</u> DUE TO <u>Squamous cell carcinoma of tongue</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>141X</u> DUE TO <u>Squamous cell carcinoma of tongue</u> (c) <u>141X</u> DUE TO <u>Squamous cell carcinoma of tongue</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-3-56</u> , 19 <u>56</u> , to <u>12-15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-15</u> , 19 <u>56</u> , and that death occurred at <u>5:15p. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.C. Dick</u>		ADDRESS (Street, city or town, state) <u>Chestertown, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>		DATE SIGNED <u>12-17-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/18/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Wells</u>		ADDRESS <u>Chestertown, Md.</u>	24a. REC'D BY REGISTRAR <u>Dec. 18-1956</u>
		24b. REGISTRAR'S SIGNATURE <u>Clara L. Barnes</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU K. 8

DEC 20 1956

RECEIVED
DEC 20 1951

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12595

CERTIFICATE OF DEATH

12578
202
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 3 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hospital				d. STREET ADDRESS RFD Tolchester			
3. NAME OF DECEASED (Type or print) Catherine Mary Martenet				4. DATE OF DEATH Dec. 18, 1956			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 14, 1899	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11. BIRTHPLACE (State or foreign country) Washington, D. C.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Jefferson Davis				14. MOTHER'S MAIDEN NAME Susie Hoskins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. no			
17. INFORMANT Martenet Address R.F.D. Tolchester St. Clair, Rock Hall, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 443 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardio-vascular disease DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 2 1/2 weeks years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan. 1952 to Dec. 18, 1956 , that I last saw the deceased alive on Dec. 17, 1956 , and that death occurred at 8:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rock Hall, Md. DATE SIGNED Dec. 19, 1956							
ACTUAL SIGNATURE Willard F. Smith M.D. Rock Hall, Md.				DATE SIGNED Dec. 19, 1956			
PHYSICIAN'S NAME (Type) Willard F. Smith - Rock Hall, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Dec. 21, 1956		Loudon Park Cem.		Baltimore, City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Willis Wells ADDRESS Chestertown, Md.				24a. REC'D BY REGISTRAR Dec. 20-56		24b. REGISTRAR'S SIGNATURE Charles L. Barnes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED <i>John Doe</i></p>		<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>	
<p>DATE OF DEATH <i>Dec 25 1956</i></p>		<p>TIME OF DEATH <i>10:30 AM</i></p>		<p>PLACE OF DEATH <i>Home</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>MANNER OF DEATH <i>Natural</i></p>		<p>EDUCATION <i>High School</i></p>	
<p>OCCUPATION <i>Teacher</i></p>		<p>RELIGION <i>Methodist</i></p>		<p>US BIRTH <i>Yes</i></p>	
<p>DATE OF BIRTH <i>Dec 10 1911</i></p>		<p>PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>DATE OF ENTRY <i>1911</i></p>	
<p>DATE OF DEPARTURE <i>Dec 25 1956</i></p>		<p>PLACE OF DEPARTURE <i>Home</i></p>		<p>DATE OF RETURN <i>Dec 25 1956</i></p>	
<p>DATE OF DEATH <i>Dec 25 1956</i></p>		<p>TIME OF DEATH <i>10:30 AM</i></p>		<p>PLACE OF DEATH <i>Home</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>MANNER OF DEATH <i>Natural</i></p>		<p>EDUCATION <i>High School</i></p>	
<p>OCCUPATION <i>Teacher</i></p>		<p>RELIGION <i>Methodist</i></p>		<p>US BIRTH <i>Yes</i></p>	
<p>DATE OF BIRTH <i>Dec 10 1911</i></p>		<p>PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>DATE OF ENTRY <i>1911</i></p>	
<p>DATE OF DEPARTURE <i>Dec 25 1956</i></p>		<p>PLACE OF DEPARTURE <i>Home</i></p>		<p>DATE OF RETURN <i>Dec 25 1956</i></p>	

BUREAU V. 2

DEC 26 1956

RECEIVED

12597

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown R.F.D.</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fairlee</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Edward</u> Last <u>Rowsey</u>				4. DATE OF DEATH Dec. <u>xx</u> 9th 19 <u>56</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16, 1884</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lafayette Rowsey</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Hosetter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT Address <u>Nora N. Rowsey Fairlee Chestertown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Cardiovascular renal disease; hypertension</u> (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>???</u> <u>????</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 5, 1956</u> to <u>Dec. 9, 1956</u> , that I last saw the deceased alive on <u>Dec. 8, 1956</u> , and that death occurred at <u>6:27</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A.C. Dick</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Chestertown, Maryland 12-10-56</u>					
PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 11, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Double Creek Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Queen Anne Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>				24a. REC'D BY REGISTRAR <u>Dec. 11-1956</u>		24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS		21. SIGNATURE OF WITNESS	
22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS	
28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS	
34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS		39. SIGNATURE OF WITNESS	
40. SIGNATURE OF WITNESS		41. SIGNATURE OF WITNESS		42. SIGNATURE OF WITNESS	
43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS		45. SIGNATURE OF WITNESS	
46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS		51. SIGNATURE OF WITNESS	
52. SIGNATURE OF WITNESS		53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS	
55. SIGNATURE OF WITNESS		56. SIGNATURE OF WITNESS		57. SIGNATURE OF WITNESS	
58. SIGNATURE OF WITNESS		59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS		63. SIGNATURE OF WITNESS	
64. SIGNATURE OF WITNESS		65. SIGNATURE OF WITNESS		66. SIGNATURE OF WITNESS	
67. SIGNATURE OF WITNESS		68. SIGNATURE OF WITNESS		69. SIGNATURE OF WITNESS	
70. SIGNATURE OF WITNESS		71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS	
73. SIGNATURE OF WITNESS		74. SIGNATURE OF WITNESS		75. SIGNATURE OF WITNESS	
76. SIGNATURE OF WITNESS		77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS	
79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS		81. SIGNATURE OF WITNESS	
82. SIGNATURE OF WITNESS		83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS	
85. SIGNATURE OF WITNESS		86. SIGNATURE OF WITNESS		87. SIGNATURE OF WITNESS	
88. SIGNATURE OF WITNESS		89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS	
91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS		93. SIGNATURE OF WITNESS	
94. SIGNATURE OF WITNESS		95. SIGNATURE OF WITNESS		96. SIGNATURE OF WITNESS	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS	
100. SIGNATURE OF WITNESS		101. SIGNATURE OF WITNESS		102. SIGNATURE OF WITNESS	

BUREAU V. 3

DEC 13 1956

RECEIVED